

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013212	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/05/2015
NAME OF PROVIDER OR SUPPLIER BARRINGTON OF CARMEL, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1335 S GUILFORD ROAD CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00179994.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to IN00178092 and IN00178546.</p> <p>Complaint IN00179994 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 2 & 5, 2015</p> <p>Facility Number: 013212 Provider Number: 155817 AIM Number: NA</p> <p>Residential: 64</p> <p>Sample: 5</p> <p>The Barrington of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00179994.</p> <p>Quality Review was completed by 21662 on October 8, 2015.</p>	R 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE